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SUMMARY ANALYSIS OF SB 248

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After barely 72 hours of consideration, the Michigan Senate, on April 16, 2015, passed SB 248, which, if enacted, will dramatically alter the Michigan auto no-fault system. This Bill would: (1) significantly reduce reimbursements to medical providers; (2) substantially limit attendant care benefits to catastrophically injured patients who are cared for at home; (3) create a new catastrophic claims commission for accidents occurring after the effective date of the legislation; (4) create a new insurance fraud authority; and (5) adopt a new test to determine if insurance premiums are excessive. CPAN believes this bill is seriously flawed, will create great instability in the Michigan auto no-fault system, impair patient access to medical care, seriously reduce revenue to the Michigan health care industry, result in a significant loss of jobs, and completely fail to reduce auto insurance premiums for the majority of Michigan citizens. The highlights of the Bill are summarized below.

I. LOWER REIMBURSEMENTS TO HEALTH CARE PROVIDERS

A. BILL CONTENT

(1) ***Mandatory negotiation between insurers and health care providers*** – if a dispute arises between a medical provider and an insurer regarding the provider's charge, the insurer and the provider *"shall negotiate to attempt to agree on a reasonable payment."* Presumably, payment can be withheld during the negotiation process.

(2) ***If negotiations fail, insurers are not required to pay any more than an "average" of payments from other sources*** – the Bill provides that *"if the parties are unable to reach an agreement, the insurer . . . is not required to pay an amount that exceeds the average amount the person or institution customarily accepts from all sources for like products, services and accommodations in cases not involving personal protection insurance, the program for medical assistance for the medically indigent under the Social Welfare Act . . . or the Federal Medicare Program. . . ."*

B. CONCERNS AND CONSEQUENCES

(1) ***Confusion over the negotiation process*** – the Bill contains no details whatsoever regarding how the mandatory negotiations between insurers and health care providers will occur. Is this through a court? A third-party? In writing? In person? Moreover, there are no details with regard to how long the negotiation process can go on.

(2) ***Complete uncertainty about the amount of provider reimbursement*** – the Bill provides no guidance on how to compute the *"average"* that will be used to determine the amount of reimbursement to providers. What sources of payment must be used in computing the average? Is it a traditional average or a weighted average? Over what period of time is the average to be calculated? What constitutes *"like"* products, services, and accommodations that must be included in the computation of the average? For hospital bills, does the average apply to the total bill or to each individual charge in the bill? None of these questions are addressed in SB 248, thereby creating complete confusion regarding provider reimbursement.

(3) ***Delays in payments to health care providers*** – since the Bill provides no guidance on the computation of the *"average,"* insurers will likely be able to withhold reimbursement while they *"negotiate"* and while they attempt to compute exactly what is payable under the *"average"* formula referenced in the bill.

(4) ***Significant increase in litigation likely*** – because of the many unanswered questions regarding provider reimbursement, the Bill will likely result in a drastic increase in the filing of lawsuits seeking judicial clarification of the computation of the appropriate *"average"* that should be utilized in calculating reimbursements. Moreover, litigation is likely to arise regarding the unclear negotiation process that is mandated by the Bill. This increase in litigation is completely contrary to the intent of Michigan's no-fault system, which is to expedite the payment of claims, minimize payment disputes, and avoid unnecessary litigation.

(5) ***Reduced access to health care*** – because the Bill creates so much uncertainty regarding provider reimbursements and is likely to force litigation, it is probable that a number of providers will become so frustrated with the process that they will no longer be able to treat auto accident patients.

(6) ***Job losses and lower tax revenue*** – in light of the fact that the Bill is intended to substantially lower the amount of reimbursement to health care providers, those providers who operate on thin margins will lose critical revenue that could result in the closure of many health care facilities. If that happens, a substantial number of Michigan citizens will lose their jobs, which will lower tax revenues for State and Local governments.

(7) ***Increased health care costs*** – the uncertainty over provider reimbursements will require many providers to litigate their claims against insurers and employ additional consultants to help them navigate the newly imposed *"negotiation"* process. This will

result in a significant increase in provider overhead, which will then likely result in higher health care costs for everyone.

II. CREATION OF THE "FRAUD AUTHORITY"

A. BILL CONTENT

(1) ***A new insurance industry controlled fraud authority is created*** – the Bill creates a new entity referred to as the *"Automobile Insurance Fraud Authority"* that purports to address so-called fraud in the auto no-fault insurance system. The Fraud Authority will raise $21 million for the purpose of studying fraud, but is given no power to prosecute when fraud is actually discovered.

(2) ***The Fraud Authority can investigate all others, but not insurance companies*** – under the Bill, the Fraud Authority is created to deal with *"automobile insurance fraud,"* which is defined as acts of fraud as enumerated in MCL 500.4503. Under that section, insurance fraud is limited to those acts that are committed against an insurance company, not acts of deceit and unfairness committed by insurance companies against the patients. Therefore, the Bill does not authorize the Fraud Authority to investigate the conduct of insurance companies and study the impact that such insurer conduct may have on auto insurance premiums in Michigan.

(3) ***The Fraud Authority is controlled by insurance companies*** – under the Bill, the Fraud Authority is run by a board of directors that consists of 15 members, 8 of which are representatives of the insurance industry, thereby giving the insurance industry control of the board.

(4) ***Compelled data collection*** – under the Bill, all insurance companies, as well as the Michigan State Police, are required to report data to the Fraud Authority. This submission of data is compulsory. For example, the Bill states, *"the Department of State Police shall cooperate with the Authority and shall provide available motor vehicle fraud and theft statistics to the Authority on request."*

(5) ***Mandatory reporting to the Legislature*** – under the Bill, the Fraud Authority is required to make annual reports to the Michigan Legislature and those *reports "must detail the automobile insurance fraud occurring in this State for the previous year, assess the impact of the fraud on rates charged for automobile insurance, summarize prevention programs, and outline allocations made by the Authority."*

B. CONCERNS AND CONSEQUENCES

(1) ***No investigation of insurance companies*** – the Fraud Authority's power is limited to offenses that violate MCL 500.4503, which does not address acts of abuse, fraud, or

overreach by insurers. Accordingly, the scope of the Fraud Authority under this Bill is limited purely to supposed fraud committed by individuals against insurance companies and does not require any scrutiny of insurer conduct, regardless of how unfair or abusive that conduct may be.

(2) ***Inadequate public representation*** – under the Bill, there is only one member of the Fraud Authority who *"represents the general public."* There is no allowance for representatives from any consumer groups. Thus, at best, consumers will be specifically represented by only one member of a 15-member board.

(3) ***A flawed concept*** – under the Bill, the Fraud Authority has no power to conduct true criminal investigations regarding actual acts of fraud. For example, the Bill gives the board no subpoena power to compel witness testimony or to produce documents. Similarly, the Bill does not give the Fraud Authority any power to refer fraud cases to prosecutors who might be able to take real action to do something about the fraud that was exposed.

(4) ***Potential intimidation of individual citizens*** – the Bill will create a $21 million dollar pot of money that insurers can use to gather any data that insurers believe is relevant to fraud. There appears to be no real control on what information can be requested and gathered by the Authority. Can the Fraud Authority request the State Police to provide investigative information about any citizen or medical provider that the Fraud Authority is interested in learning about? Can the Fraud Authority disregard the privacy rights of individual citizens in pursuit of its search for information? Will the Fraud Authority use its power to intimidate persons and entities who it perceives are *"enemies"* of insurance companies? These concerns are particularly important because there is absolutely no consumer or privacy protections referenced in the Bill.

(5) ***Creation of another insurance industry money pot*** – under this Bill, the insurance industry will be able to collect millions of dollars and deposit those funds into an account over which it has sole control. This will provide the insurance industry with the opportunity to compile data and write reports based on a one-sided investigation of auto no-fault insurance abuses, while at the same time, shielding the insurance industry from any real public scrutiny. Michigan citizens do not need another insurance industry bureaucracy that collects and spends huge sums of money and is not answerable to the public.

III. ATTENDANT CARE

A. BILL CONTENT

(1) ***Imposition of an hourly rate cap for care provided by family or household members*** – SB 248 imposes an hourly rate cap of $15 per hour for attendant care provided to an

injured person by his or her family or household members. However, the Bill does not provide any definition of the phrase *"family or household member."*

(2) ***The hourly rate cap will only be adjusted every three years for changes in Consumer Price Index***—SB 248 provides that the $15 hourly rate cap will only be increased every three years to reflect *"the aggregate percentage change in the United States Consumer Price Index, rounded to the nearest 10 cents."*

(3) ***The hourly rate cap applies regardless of the level of care***—SB 248 explicitly states that the hourly rate cap applies *"regardless of level of care provided"* by the family or household member.

(4) ***The hourly rate cap applies regardless of whether the family or household member is a licensed care provider***—SB 248 explicitly states that the hourly rate cap applies *"regardless of whether the family or household member is licensed or otherwise authorized to render the attendant care under Article 15 of the Public Health Code, 1978 PA 368, MCL 333.16101 to 333.18838 . . ."*

(5) ***The hourly rate cap applies regardless of whether the family or household member is employed by or under contract with a licensed care provider or agency***— SB 248 further states that the $15 hourly rate cap applies regardless of whether the family or household member is *"employed by, under contract with, or in any way connected with an individual or agency who is licensed or authorized to render the care."*

(6) ***Attendant care is cumulatively capped at 24 hours per day, unless approved through medical review***—SB 248 provides that an insurer is not liable to pay for more than 24 hours of daily attendant care rendered to an injured person, regardless of whether the care is rendered by commercial or noncommercial care providers, and regardless of the number of caregivers required. However, SB 248, provides that an injured person seeking attendant care in excess of 24 hours per day can *"request a medical review"* to determine if the person requires care in excess of 24 hours per day. If the medical review process determines that 24 hours per day is necessary for the injured person, the insurer is liable for those hours of care. However, this provision does not provide any explanation of how this medical review should be conducted or who should conduct it.

B. CONCERNS AND CONSEQUENCES

(1) ***Family-provided attendant care model jeopardized***—the hourly rate cap in SB 248 may jeopardize the cost-effective and efficacious family-provided attendant model, which allows the injured person to receive care from those who know the person the best and care about the person the most. This will be the case especially with regard to the most catastrophically injured people who need highly skilled nursing care.

(2) ***Increase the financial burden on the no-fault system***—the hourly rate cap will cause many families to hire commercial nursing care, which is significantly more expensive

for the no-fault insurers than paying family or household members to provide noncommercial care. This will ultimately increase the financial burden on the Michigan no-fault system.

(3) ***Many injured people will not have access to in-home attendant care*** – commercial agencies are frequently able to provide attendant care to injured people, especially those in rural and/or remote areas, by hiring and training family or household members to provide the care through the nursing agency. A major reason for agencies utilizing this option is because of the high cost of paying for the time and expenses associated with its employees traveling to rural and/or remote areas. If the nursing agency cannot afford to limit its reimbursement rate to $15 per hour for the care provided by a family or household member, the nursing agency will not have the option of hiring the injured person's family or household members.

(4) ***Uncertainty for the most catastrophically injured*** – catastrophically injured people often require a cumulative total amount of daily attendant care that exceeds 24 hours per day. Under SB 248, the only way these people can receive payment for attendant care is by going through the undefined and unexplained *"medical review"* process. Because there is no guidance to this process, catastrophically injured people will face enormous uncertainty regarding whether they will be able to receive the amount of care that they require.

IV. MICHIGAN CATASTROPHIC CLAIMS COMMISSION (MC3)

A. BILL CONTENT

(1) ***Creation of the MC3*** - SB 248 allows for the creation of a new entity known as the Michigan Catastrophic Claim Commission (MC3). This entity will take over the new catastrophic claims going forward.

(2) ***The MC3 assumes all financial liability for catastrophic claims*** - SB 248 specifically provides that the MC3 will assume *"100% of all liability"* for the losses over and above the monetary threshold for catastrophic claims. This is a drastic change from the current law, which provides that the MCCA only indemnifys the responsible insurers for those losses.

(3) ***The MC3 takes over adjusting responsibility for all catastrophic claims*** - SB 248 specifically provides that the MC3 will take over the adjusting responsibility of catastrophic claims. Therefore, catastrophically injured people and their providers will have to interface directly with the MC3 in order to receive payment of their claims.

(4) ***Dissolution of the MCCA*** - SB 248 lays the groundwork for dissolving the MCCA. The MCCA will remain financially responsible for the claims it currently handles, but once those claims are closed, the MCCA will be dissolved.

B. CONCERNS AND CONSEQUENCES

(1) ***No protection from MC3 Insolvency*** - SB 248 does not provide any protection in the event the MC3 goes insolvent. This is a major concern, given that the MC3 will assume complete financial liability for all claims that exceed that monetary threshold for catastrophic claims.

(2) ***MC3 likely not covered by Michigan Property Causality & Guaranty Association*** - SB 248 does not make it clear whether the MC3 is covered by the Michigan Property Causality & Guaranty Association. If it is not, this would mean there is no law or procedure law that would govern any potential insolvency of the MC3.

(3) ***No protection against the MCCA from disbursing its surplus to its current MCCA members*** - SB 248 does not provide any protection from the MCCA dispersing its surplus to its current members. Considering the enormous amount of money within the MCCA, explicit language must be added that protects any surplus of the MCCA from being dispersed to its members.

(4) ***No standards of fairness applicable to MC3 claim handling*** - SB 248 does not require the MC3 to apply any standards of fairness to how it handles and adjusts claims of catastrophically injured claimants. This could result in the MC3 handling claims in an unfair and adversarial manner.

(5) ***The Need for Actuaries on the MC3 Board*** - SB 248 requires the MC3 board of directors to have 7 members, but does not require that any of those members are actuaries. In order to make sure that the board properly assesses its risks, the board should include at least two actuaries.

V. RATE CONTROL

A. BILL CONTENT

(1) ***No premium reductions***—there is nothing in this Bill that requires insurance companies to reduce auto insurance premiums by a single penny. Moreover, there is nothing in the Bill that requires insurance companies to control the rate of premium increases in the future.

(2) ***New definition of excessive rates***—in an attempt to do something about the issue of insurance rates, the Bill redefines what is an excessive rate, by stating, *"a rate is excessive if it is likely to produce a profit that is unreasonably high in relation to the risk involved or if the cost of the insurance is unreasonably high in relation to services rendered."*

B. CONCERNS AND CONSEQUENCES

(1) ***No specificity*** – in spite of the fact that the Bill attempts to do something about excessive rates, it offers no definition of the operative phrase requiring proof *of "a profit that is unreasonably high."* What does this mean? How is it demonstrated? In what forum is this issue to be raised?

(2) ***Increase in litigation likely*** – in light of the fact that the Bill provides no meaningful guidance regarding the definition of an *"excessive rate"* or how it is to be calculated, the Bill is likely to result in numerous lawsuits challenging the no-fault rate structure. These lawsuits will create more confusion regarding the auto no-fault system, unnecessarily burden the Michigan court system, increase overhead for insurance companies, and drive up costs for everyone.